

Clinical Policy: Behavioral Health Treatment Documentation Requirements

Reference Number: HIM.CP.BH.500

Date of Last Revision: 04/26

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Documentation in a medical record facilitates patient safety, decreases error, improves quality of care, and ensures regulatory and reimbursement compliance. Behavioral health services must meet specific requirements and be documented in a manner that adheres to applicable regulations, accreditation standards, and professional practice standards.

Policy/Criteria

I. It is the policy of Centene Advanced Behavioral Health and health plans affiliated with Centene Corporation® that Health Insurance Marketplace behavioral health treatment records must contain at a minimum all the following elements, in addition to any state required components:

Note: Billed units not fully supported by documentation may be subject to payment denial or recoupment.

A. All entries in the treatment record are legible to another person other than the writer, dated and signed/authenticated (including licensure and/or certification) by the rendering provider prior to submission of the claim;

B. Rendering provider meets all of the following:

1. Independently licensed in the state in which the provider is rendering and billing the services;
2. Rendering provider on the claim is the same individual that performed the service;
3. Provides services within the scope of their individual licensure.

Note: The following are examples (not all-inclusive) of provider types licensed to provide behavioral health services such as group, individual or family psychotherapy, mental health evaluation, and other clinical assessments:

- a. Licensed Clinical Social Worker (LCSW);
 - b. Licensed Marital and Family Therapist (LMFT);
 - c. Licensed Psychologist (LP);
 - d. Licensed Psychological Examiner – Independent (LPEI);
 - e. Licensed Professional Counselor (LPC);
 - f. Licensed Alcohol and Drug Abuse Counselor (LADAC);
 - g. Advanced Practice Registered Nurse (APRN);
 - h. Doctor of Medicine (MD);
 - i. Doctor of Osteopathic Medicine (DO);
4. Provider type is not one of the following (list is not all-inclusive):
- a. Counselors in Training (CIT);
 - b. Rehab Day Specialists (RDS);
 - c. Licensed Associate Counselor (LAC);
 - d. Licensed Master Social Worker (LMSW);
 - e. Licensed Associate Counselor (LAC);

CLINICAL POLICY

Behavioral Health Documentation Requirements

- f. Provisionally Licensed Psychologist (PLP);
- C. Member/Enrollee's name is documented on each page;
Note: If the legal name differs from the preferred name, the legal name is noted at the top of the note. The preferred name should be noted in parentheses and used in the rest of the documentation.
- D. Date of service (DOS) is documented at the top of each note and no less frequently than on each page;
- E. Mental health diagnosis listed meets criteria noted in the most current version of the Diagnostic and Statistical Manual of Mental Disorders and is consistent with the following:
 - 1. Member/enrollee's presenting problems;
 - 2. Symptom history;
 - 3. Mental status examination;
 - 4. Other assessment data;
- F. Certification of the mental health diagnosis is rendered by a qualified practitioner;
- G. Type of service provided, with applicable code;
- H. Exact start and stop times of the service;
- I. Reason for service (problem statement);
- J. Each service encounter is individualized to the member/enrollee and specific date of service;
- K. Results of required screenings, assessments, or reassessments;
- L. Documentation supports medical necessity and clearly justifies the requested frequency, intensity and duration of requested services based on the member/enrollee's current clinical presentation;
- M. Treatment plans meet all the following:
 - 1. Plan for ongoing treatment (i.e., plan for next sessions) is consistent with member/enrollee diagnoses;
 - 2. Contains objective, measurable goals and estimated timeframes for goal attainment or problem resolution;
 - 3. Includes a preliminary transition/discharge plan, individualized to the member/enrollee's needs;
 - 4. Completed by a qualified practitioner in accordance with applicable state guidelines and the member/enrollee's health plan requirements;
 - 5. Reviewed with the member/enrollee and caregiver/guardian, as applicable, within the timeframes required by applicable state guidelines and/or the member/enrollee's health plan;
- N. Clear clinical/therapeutic interventions and member/enrollee response to the interventions;
- O. Interventions are evidence-based and clearly linked to the member/enrollee's diagnosis, behavioral health needs, and individualized treatment goals;
- P. Identification of all individuals who actively participated in the sessions, to include the relationship with the member/enrollee;
Note: PHI or PII data for non-member/enrollees should not be included.
- Q. Summary of progress or lack of progress toward identified goals, with care plan changed accordingly to meet the current need;

CLINICAL POLICY

Behavioral Health Documentation Requirements

Note: When progress is not demonstrated, documentation must include clear clinical rationale explaining contributing factors and justification for continuation of services.

- R. Addenda created to supplement documentation after the completion of the original clinical note, include all the following (as applicable);

Note: Addenda are intended to clarify or correct existing documentation and not substantively modify the nature, duration, or content of services rendered.

1. Clear reference to the original clinical note being supplemented;
 2. Date of note completion;
 3. Legible name, signature, and credentials of rendering provider
- S. Discharge summary, if applicable includes all of the following:
1. Summary of care, treatment, and services provided;
 2. Member/enrollee's condition at the time of discharge;
 3. Rationale/reason for discharge;
 4. Written discharge instructions including referrals, follow-up care, and medication regimen, as applicable.

Background

*The Centers for Medicare and Medicaid Services (CMS)*¹

Documentation often serves as the primary method of communication between practitioners to ensure ongoing patient needs are met. Federal and State laws also require practitioners to maintain the records necessary to “fully disclose the extent of the services,” care, and supplies furnished to beneficiaries, as well as support claims billed. Each patient encounter needs to be documented completely, accurately, and in a timely manner. Records that are not properly documented with all relevant and important facts can prevent the next practitioner from furnishing sufficient services. Unclear and inconsistent documentation can lead to unintended complications and gaps in care as well as denial of claims.

*The Joint Commission*²

The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by inspiring healthcare organizations to excel in providing safe and effective care of the highest quality and value. “Documentation of Care, Treatment, or Services in Behavioral Health Care” is a book published by The Joint Commission to help organizations maintain compliance and effectively use documentation to drive positive outcomes for individuals served. Per The Joint Commission, documentation affects every aspect of care, treatment, or services and outlines the importance of accurate, timely, and appropriate documentation in behavioral health care.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

CLINICAL POLICY
Behavioral Health Documentation Requirements

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New policy developed. Modified CP.BH.500 to be specific to Health Insurance Marketplace with the following changes: included in the policy statement in I. that the policy applies to HIM plans affiliated with Centene and added rendering provider requirements in I.B.	03/24	03/24
Annual review. Description and background updated with no impact to criteria. Criteria statements reorganized for clarity. Updated policy statement I. to reflect “all” behavioral health treatment records...and all of the following elements, “as applicable.” Reworded criteria in I.E., and I.F. for clarity. Added criteria I.I. “Each service encounter...” and criteria I.J. “Results of required screenings...” Moved previous criteria I.N. “Plan for ongoing treatment...” under Treatment plan in I.L.1. Added Discharge summary criteria in I.Q.1-4. References reviewed and updated.	03/25	03/25
Annual review. In policy statement I removed "Centene Advanced Behavioral Health". Added a note " Billed units not fully...". In I.C. added note "If legal name differs from the preferred name...". Added I.F. “Certification of the mental health diagnosis is rendered...” In. I.G. added "...with applicable code". In. I.L. clarified the statement by adding that documentation supports and clearly justifies the requested frequency and duration of services based on the member/enrollee’s current clinical presentation. Added I.M.4 and I.M.5 to attest to review the treatment plan within state-approved guidelines and timeframes. Added “evidenced based” to I.O. Added new I.P. " Identification of all individuals who actively participated..." with an accompanied note on PHI data. Added I.Q. " When progress is not demonstrated..." with an accompanied note to document that the addenda is intended to clarify or correct existing documentation. Added I.R. and accompanying note "Addenda created to supplement...". Background reviewed. References reviewed and updated.	04/26	05/26

References

- Centers for Medicare and Medicaid Services (CMS). Medicaid Documentation for Behavioral Health Practitioners Fact Sheet. <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/docmatters-behavioralhealth-factsheet.pdf>. Published December 2015. Accessed April 28, 2026.
- The Joint Commission. Documentation of Care, Treatment or Services in Behavioral Health Care. https://digitalassets.jointcommission.org/api/public/content/assets/1/7/ebbh23_sample_pages.pdf. Published 2023. Accessed April 28, 2026.
- Noridian Medicare. Jurisdiction E. Medicare Part B. Mental Health Documentation Requirements. <https://med.noridianmedicare.com/web/jeb/topics/documentation->

CLINICAL POLICY

Behavioral Health Documentation Requirements

[requirements/mental-health](#). Updated August 23, 2024. Accessed April 28, 2026.

4. Mental Health First Aid National Council for Behavioral Health. Position Statement on Generally Accepted Standards of Care for Behavioral Health. <https://www.thenationalcouncil.org/resources/position-statement-on-generally-accepted-standards-of-care-for-behavioral-health/>. Published February 3, 2022. Accessed April 28, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to documentation, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

CLINICAL POLICY

Behavioral Health Documentation Requirements

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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